AARP

July 14, 2003

The Honorable John D. Dingell, Ranking Member
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Dingell:

Congress and the Administration now have the opportunity to make one of the most important changes to Medicare since the enactment of the program – the addition of prescription drug coverage. We appreciate the efforts made thus far by both the House and Senate in passing their respective bills. Much has been accomplished. Both bills would provide a voluntary prescription drug benefit, with equal drug benefit subsidies, to all beneficiaries, and include assistance for low-income beneficiaries and those with high drug costs, as well as improvements in chronic care and prevention. But more still needs to be done before final legislation should be enacted.

As the conference commences, we believe there is an opportunity to produce a better bill than the ones passed by either house. To realize that potential, we urge you to correct serious problems that exist in both bills so that the final conference report is one that garners broad bipartisan support. We know that legislation of this scope can never fully satisfy every interested party. Nevertheless, there are a number of fundamental issues – primarily the program structure and the adequacy and affordability of the benefit package – that must be fixed before AARP and its members could support the final conference agreement.

STRUCTURE

Premium Support

The House bill establishes a new competitive structure that would require traditional Medicare to compete against private plans without the flexibility that private plans have to control costs. The Senate bill does not include this provision.

Starting in 2010, fee-for-service premiums would no longer be based solely on Part B spending. The Medicare Part B premium would be adjusted in a region based on the average of all Medicare spending – fee-for-service and private plan bids – in that region. If traditional Medicare costs more than the average of all plan costs, then the Part B premium will be increased to make up the difference.

This will lead to an inherently unfair system: Medicare+Choice experience strongly suggests that private plans will enroll younger and healthier beneficiaries, leaving older and sicker individuals to drive up traditional Medicare spending rates. In addition, private plans could undercut bids in some years, eating short-term losses in order to increase market share, and then raise rates in later years to make up the difference. The fee-for-service Medicare program cannot do that, as its costs are largely determined by statutory coverage policies, payment formulas, and utilization rates that are controlled by physicians.

The result would inevitably be higher costs for those who want to stay in the traditional program. In fact, the CMS actuary estimates that this could increase fee-for-service premiums by up to 25 percent.

AARP opposes a premium support structure, such as in the House bill, that could destabilize the Medicare program and require beneficiaries to pay even more out-of-pocket. Despite the phase-in, the model in the House bill does not create a level playing field and in fact will penalize those who choose to remain in traditional Medicare. We believe that the proposed system could actually limit beneficiary choice by making the traditional program unaffordable for those who tend to be sicker, and for those who do not choose to enroll in a private plan. Even with the best risk adjustment available today, the premium support proposal in the House bill would likely harm traditional Medicare and those who depend on it. Any final conference agreement that retains this provision will not be in the best interests of Medicare beneficiaries or the program.

A Guaranteed Prescription Drug Benefit

Both the House and Senate bills rely on private plans to offer the Medicare drug benefit. The House bill does not provide a guarantee that a stable drug benefit will be available in all parts of the country. Instead, the bill authorizes the Secretary of the Department of Health and Human Services (HHS) to negotiate with plans by reducing financial risk to encourage private plans to step forward. The Senate bill, in contrast, requires that if at least two plans are not approved in each region, the Center for Medicare Choices (CMC) must first reduce risk for plans in that region. If there still were not two approved plans, CMC would then contract with a plan to provide the standard drug plan coverage – a guaranteed government fallback.

AARP believes that there must be a guaranteed drug plan available for all Medicare beneficiaries – regardless of where they live. Stand-alone drug plans generally do not exist in the private market and it is still unclear whether the insurance industry will view stand-alone plans as an attractive business opportunity. The Senate provision is the minimum necessary to ensure coverage in all parts of the country.

Even the fallback approach could result in instability because the government contract would be for only one year and would not be renewed if a private plan subsequently entered its region. Beneficiaries would be forced to jump in and out of private plans as they come and go in various markets, as with Medicare+Choice. It also could result in private plan options that vary greatly by region, leading to possible inequities in premiums across the country.

Beneficiaries must have a guarantee that the government will step forward if needed to ensure access by providing a viable, guaranteed federal "fallback" with a defined benefit and a defined premium in all areas where fewer than two stand-alone plans are available. Any fallback plan should be guaranteed for longer than one year.

Means Testing

One of the fundamental principles and core strengths of the Medicare program is its social insurance nature. Working Americans pay into the program through the FICA payroll tax and are eligible for benefits upon reaching age 65 – regardless of health status or income.

The House bill would – for the first time in the program's history – vary the Medicare benefit based on income. Specifically, the level of the prescription drug catastrophic cap would be higher for those with incomes above a specific threshold. The Senate bill does not include such a provision. The argument that beneficiaries with higher incomes can afford to pay more for their benefits fails to recognize that individuals with higher incomes have already paid more through higher Medicare payroll taxes during their working lives – and many continue to contribute to Medicare through general tax revenues. Further, no insurance plan for individuals under the age of 65 – including plans for Members of Congress – varies benefits by income. The House bill, by reducing benefits for those with higher incomes, would create a disincentive for higher income beneficiaries to enroll in the program, further weakening the risk pool.

Medicare must remain a program in which everyone who pays in receives the benefit. Altering the level of the benefit based on beneficiary income would erode the universal nature of the program.

Low-Income

We are encouraged that both the House and Senate bills would provide additional assistance to low-income beneficiaries. We urge the conferees to improve these provisions further. The House bill includes all Medicare beneficiaries – including "dual eligibles" – in the prescription drug benefit. The Senate bill would require dually eligible beneficiaries to continue to rely on whatever Medicaid drug benefit is provided in their state, rather than the Medicare benefit. AARP believes that all Medicare beneficiaries should have access to the Medicare drug benefit and that states should be able to wrap-around the Medicare benefit. To do otherwise would set a bad precedent that would result in a Medicare benefit not being available to all beneficiaries. The universality of the benefit is another lynchpin of the Medicare program and should not be altered.

Both bills have made improvements in the level of the assets test imposed on low-income beneficiaries, however we believe that eligibility for this assistance should not be limited by an assets test that could prevent otherwise low-income beneficiaries from the benefit of reduced cost sharing.

The House bill does not provide any coverage for low-income beneficiaries in the "doughnut hole." This means that low-income beneficiaries could find themselves with no protection at a time when they need it most. A primary strength of these bills lies in the low-income protections and we believe that costs must be covered without gaps in order to ensure that low-income Americans will be able to afford the drugs they need to stay healthy.

ADEQUACY OF THE BENEFIT PACKAGE

Coverage Gap

The ultimate test for a successful Medicare prescription drug benefit is whether it will provide needed relief for Medicare beneficiaries. Coverage needs to be affordable and attractive enough to ensure enrollment of a large enough pool of beneficiaries so that the program will work. Attracting only those with the highest drug costs will render the program unsustainable over time.

Our research has consistently shown us that our members' enrollment decisions are influenced by the adequacy and complexity of the benefit. Chief among their concerns is the gap in coverage. Both the House and Senate made efforts to reduce the size of the "doughnut" from the original levels. However, AARP believes the remaining coverage gap is simply bad policy, is unnecessarily confusing, and will prove to be a disincentive to enrollment. The gap should be narrowed further and, ultimately, must be eliminated.

Maintaining Current Coverage

Employer plans are the single largest source of prescription drug coverage for Medicare beneficiaries, covering about 12 million people. This coverage is often more generous than that provided under either bill, which does not count such coverage when determining whether beneficiaries receive Medicare's out-of-pocket cost protection. We are alarmed by the estimate of the Congressional Budget Office (CBO) that over thirty percent of beneficiaries with coverage are estimated to lose employer coverage under these bills. Roughly four million Medicare beneficiaries would find – in most cases – that their drug coverage had been diminished rather than improved by the enactment of a Medicare prescription drug benefit. AARP strongly believes that a conference agreement should not result in millions of older and disabled Americans losing their employer-provided prescription drug coverage.

The final conference agreement should provide adequate incentives for employers to maintain their plans. At the very least, the conference report should minimize the bills' current incentives to drop comprehensive retiree health benefits. The conference agreement should also reject any change in the age discrimination law, such as is included in the Senate bill, that would permit more employers to drop benefits for the Medicare-eligible population. The final package should also provide protections for those retirees whose employer coverage ends because of the enactment of the drug bill.

AFFORDABILITY

Indexing

Both the House and Senate bills index benefit levels to the cost of prescription drugs. Drug costs have been rising at double-digit levels well above general inflation. Failure to contain the costs of drugs in the future means that the benefit will rapidly become more unaffordable over time. For example, the initial deductible amount in both bills is projected to rise to nearly $500 by 2013.

As you know, most older American's cost-of-living adjustments are linked to the general inflation rate and most employer provided pensions are not even adjusted for inflation. As a result, beneficiary income would fall swiftly behind a benefit indexed to drug costs.

We urge you to index the prescription drug benefit and other cost-sharing measures to a measure that is more closely related to the growth in beneficiaries' ability to pay to ensure that the coverage will remain affordable over time.

Cost Containment

The high price of prescription drugs continues to be a top concern of our members. In order to assure the continued affordability of the benefit for both beneficiaries and the Medicare program, greater efforts are needed to put downward pressure on health care costs, particularly the price of drugs.

We applaud the promotion of generic drugs with the inclusion of versions of the "Access to Affordable Pharmaceuticals Act" in both the House and Senate bills. This provision is designed to remove barriers brand-name companies have used to delay entry of lower priced generic drugs into the market. We urge that the conference agreement not weaken further the provisions in the Senate bill.

The final conference report should also include measures to improve appropriate use, and improve quality prescribing. Further, cost containment strategies are needed, including:

- Develop and Disseminate Comparative Effectiveness Information: Direct the Agency for Health Research and Quality (AHRQ) and the National Institutes of Health (NIH) to sponsor and disseminate studies of comparative clinical effectiveness of drugs widely used by Medicare beneficiaries. Currently, no federal agency regularly sponsors reviews and reports on the comparative effectiveness of prescription drugs. Yet information on which drugs work best for which patients is essential in assuring that patients get the safest and most effective treatment at the lowest possible cost.

- Strengthen FDA oversight of direct to consumer advertising: Much of the growth in prescription drug spending is attributable to heavily advertised drugs. Marketing that unnecessarily drives demand for higher cost drugs or that does not appropriately address risks should be minimized. Congress should fund greater enforcement of existing FDA regulations, institute penalties for advertisements that contain false or misleading information, and require that the FDA approve all advertisements prior to their release.

Another important cost containment measure that reaches beyond prescription drugs is chronic care management. Since 50 percent of Medicare spending is attributable to just 5 percent of beneficiaries in any given year, better disease management and behavior modification programs are critical to saving money for the program and improving care for Medicare beneficiaries. Therefore, chronic care management techniques should be incorporated in the traditional Medicare program wherever possible.

Provider Givebacks

I also want to reiterate AARP's position on the use of funds from the $400 billion allocation for provider reimbursement increases. Providers should be paid fairly for treating Medicare patients, but beneficiaries have waited long enough for relief from high prescription drug costs. Every dollar allocated to "givebacks" means one less dollar available to improve the drug benefit. Increases in provider reimbursements also substantially increase beneficiary out-of-pocket costs through higher premiums and coinsurance.

We appreciate that objective analyses by MedPAC and others demonstrate legitimate need for some provider payment adjustments. However, we also note that these analyses demonstrate need for decreases in some areas as well. Any reimbursement changes should be based on sound, objective analyses, and result in no net increase that would diminish the amount of funding for a drug benefit or add to total beneficiary cost-sharing obligations.

Conclusion

The conference committee is the next critical step towards the enactment of prescription drug legislation that begins to fulfill the pledge to provide stable and affordable drug coverage to Medicare beneficiaries.

Current funding is insufficient to provide beneficiaries with the benefit they need and expect. Yet a final package can still achieve a significant down payment, and can provide much needed help for those with the lowest incomes and those with the highest costs.

At a minimum, however, any final conference agreement should not destabilize Medicare nor penalize those beneficiaries who choose to stay in the current Medicare program; should not create incentives for employers to drop retiree coverage; should ensure prescription drug coverage in all areas of the country; and should guarantee the same level of benefit to all beneficiaries regardless of income.

We believe that the conference process presents an extraordinary opportunity to achieve these goals. If, however, the final conference agreement does more harm than good, based on the concerns enumerated in this letter, we will not hesitate to oppose it. On the other hand, if our concerns are constructively addressed, we believe that the conference agreement has the potential to be better than the bills reported from either house. Congress will have taken an historic step and we could urge our members to support enactment of the final conference report into law, as well as to educate them about the new benefit and their enrollment options.

Sincerely,

William D. Novelli